THE CHALLENGE OF ADOLESCENT SEXUALITY*

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ADOLESCENT sexuality should *not* be discussed at a conference dedicated to 100 years of progress in child health, because adolescent sexuality is an area in which this society does not appear to have made much progress. Before the turn of the century females and males reached sexual maturity later than today and sexuality outside of marriage, while hardly unknown, was more severely censured. A premarital pregnancy often resulted in a marital birth, as the young man was convinced, by a shotgun if necessary, to make an honest woman of some father's daughter. Marriage, however, occurred earlier, so teen-age pregnancy and childbearing within marriage were not uncommon and early childrearing did not have some of the negative consequences now associated with it. The teen-age mother's husband was usually employed, so welfare support was not a problem. Nor was dropping out of school, since there was little expectation of high school completion for women. Teen-age pregnancy among married women was accepted by family and friends, so social support was available to help even relatively young women through the pregnancy and to assist with child care.

The situation has changed in 100 years. The most recent data (1983) on adolescent sexuality indicate that 5% of white females are sexually active by age 15 and 72% by age 20; and that among black females 10% are sexually active by age 15 and 85% by 20. Among males the rates are much higher (12% of whites are sexually active by age 15 and 81% by 20 and among black males, 42% by age 15 and 94% by age 20).[1] In addition, about 40% of teen-age pregnancies end in abortions; and more than three fifths (61.5%) of births under 20 are to unmarried women.[2] At present, a large percentage of teen-age mothers are on welfare; and social or other forms of support from the male partner or others are often limited or nonexistent.

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Although little progress has been made since 1888, considerable progress has been made in comparison to 1968, particularly in three areas. First, the number of teen-age births has declined, especially among older teen-agers. Second, the medical consequences of early childbearing have been reduced. And, third, myth has been separated from reality in terms of the causes and consequences of adolescent sexuality and, as a result, more effective programs are being developed.

Rates and Numbers

The numbers of births to teen-agers peaked during the early 1970s when the children born in the post-World War II baby boom reached the age of sexual maturity. Not only were there more young women to become pregnant and more young men to make them pregnant, but the rates of sexual activity began to climb. The Kantner and Zelnik studies of adolescent women showed an increase in sexual activity among the never married from 28% in 1971, when they conducted their first study, to 39% in 1976 at the time of their second study, to 46% in 1979 when they conducted their third and last survey.[3] Nevertheless, in comparison to the 628 thousand births to teen-agers in 1972, in 1985 there were only 472,000, a decline of almost a quarter. The teen-age birth rate has also declined: 50.6 live births per 1,000 15-19-year-old females in 1986 as compared to 61.7 in 1972. While some combination of abortion and family planning has reduced the number of adolescent births, the percentage of those births that occur outside of marriage has increased steadily.

Medical Consequences

Although the number of births to teen-agers and the rate of teen-age childbearing peaked earlier, most of the country did not become concerned about teen-age pregnancy until 1972 when the results of the first Kanter and Zelnick study of sexual activity among young women were published.[4]

And even more attention was focused on the problem in 1976 when the Alan Guttmacher Institute published its monograph, *11 Million Teenagers: What Can Be Done about the Epidemic of Adolescent Pregnancies in the United States*.[5] The wide distribution of this brochure and the response of federal and state governments made teen-age pregnancy an issue about which everyone had an opinion. Among the medical consequences of teen-age pregnancy cited in the booklet were: Babies of Young Teens Two to Three Times More Likely to Die in the First Year; Low Birthweight Twice as High Among Teen-agers; and Maternal Death Risk 60 Percent Higher for Young

Teen-agers. Although the facts were true, they were also misleading, because the teen-agers were being compared with all women who gave birth between 20 and 24 years of age. The implicit assumption was that the reason for the higher rates was the younger age. These analyses however, did not control for the fact that teen-age mothers were at greater risk for poor outcomes because a larger portion of younger than older mothers lived in poverty. And with poverty came inadequate nutrition and insufficient medical care.

Beginning in the mid-1970s comprehensive programs were developed by health institutions, schools, and social service agencies. These programs provided prenatal care to pregnant teen-agers, either directly or by referral. Many of these programs have been evaluated, and they uniformly report that rates of maternal morbidity and mortality, as well as premature labor, low birthweight, poor Apgar scores, and neonatal mortality are significantly lower among program participants than among nonparticipants. In some programs the teen-age participants have rates approaching those among women of more traditional childbearing ages.

This is another area of progress. No longer is the pregnant teen-ager ignored or shunned. Rather, programs all over the country, including many in New York City, reach out to pregnant adolescents, attempt to bring them into the health care system early in their pregnancies, and, during their pregnancies, provide continuing support for medical care, health-promoting activities, school attendance, and other positive behaviors. Often these programs extend their services into the early postpartum period or beyond, with favorable impacts on delay of subsequent pregnancies, continuation of education, and infant health and development. Only if adolescents receive prenatal care inadequate in amount, content, or quality are they at high risk medically.

MYTHS AND REALITY

Millions of dollars in research funds have been devoted to the causes and consequences of adolescent sexuality and the effectiveness of programs to prevent early pregnancy or to ameliorate the consequences of early childbearing.

Causes. As a result of this research, many myths about the causes of adolescent pregnancy have been proved wrong. For example, it was believed that the easy availability of contraceptives might lead to earlier or increased sexual activity. But the truth is that most girls first appear at a family planning clinic a year after they initiate sexual intercourse and often because they want a pregnancy test. Moreover, the delay between first intercourse and first family planning visit can be reduced if clinics offer community education for

teens, obtain the support of local church groups, and work with local youth groups.[6] Community family planning clinics, particularly those with active programs of outreach to adolescents,[7] and school-based or school-affiliated clinics, particularly those permitted to prescribe or distribute contraceptives, can reduce the pregnancy rate.[8]

Another myth suggested that adolescent girls become pregnant deliberately. Perhaps some do, but most adolescent pregnancies are unplanned, though the infants may not be unwanted. Young women and men understand enough about what early childbearing can do to their lives not to have a child intentionally, but the consequences do not seem so dreadful that they want to go to the bother of preventing the pregnancy. They figure "it won't happen to me" and do not use an effective family planning method. A recent survey in Illinois produced two contrasting lists of why teens become pregnant. The Parent Advisory Council of a Teen Awareness Project listed as the first three reasons: feeling of wanting to belong to someone special or having something of their own to love, lack of jobs, and peer pressure or desire for popularity. The Project teens themselves listed peer pressure as the number one cause followed by public aid checks or sex for favors (clothes and money) and concern over facing life's realities. Other reasons proposed by the teen-agers themselves included: improper use of birth control, strictness of parents, enjoyment of sex, desire to lose virginity, curiosity, to gain the love that a baby provides, and to feel grown up.[9] The response about welfare checks is surprising, because other evidence indicates that teen-agers do not become pregnant to "get on welfare." In fact, the rates of pregnancy are highest in states with the lowest benefit levels.

The high ranking of peer pressure on both lists confirms what many adolescent specialists have suspected, but also suggests how hard it will be to modify sexual behavior among both female and male adolescents. It is more difficult to change activities supported by others or that are part of a larger pattern of behaviors. Researchers have discovered not only strong peer encouragement for sexual activity, but strong relationships among too early sexual activity and other forms of problem behaviors.

In the past, society has acted as though young women who became pregnant as teen-agers had made an isolated mistake. If they could be helped over this minor unpleasantness, they would then assume the life of a normal teenager, i.e., attend school and prepare for a career and marriage. It is clear that such assumptions are often incorrect. Many young women who become pregnant and boys who contribute to the pregnancy are not engaging in what their social group considers unusual or disapproved behavior. Rather, they are acting normally for their social group. Moreover, it is increasingly clear

that children, especially adolescents, are unlikely to adopt only one behavior that puts their health in jeopardy or is socially deviant. The first such activity may be relatively innocuous, such as cutting classes, smoking, or drinking beer. But if such activities are rewarded by peers and not strongly condemned by parents, teachers, or other adults they may be repeated and other potentially harmful behaviors adopted. For example, one study reported that sexually active teen-agers rated higher on an index of substance abuse than did virgins. Those high on this index were also more likely to be behind in grade.[10]

These findings have major implications for program planning. Premature or unprotected sexual activity, smoking, alcohol and drug abuse, delinquency, and similar problem behaviors probably cannot be independently addressed. They seem to be part of a group of activities reinforced by a choice of peers who approve of them and who also engage in these behaviors. Programs should focus on the early signs of risk-taking behavior to find the underlying causes of the behaviors, to prevent the formation of peer groups that share the behaviors, and to provide models for more constructive activity.

Excessive school absence without an underlying physical health problem is one of the behaviors now included in the group of risk-taking or deviant behaviors often associated with health and social problems during adolescent or adult years. Early intervention by physicians, parents, and school officials may prevent the sequelae of these problem behaviors.

Consequences. Myths about the "inevitable" consequences of adolescent pregnancy have also been dispelled. It has already been noted that if prenatal care is adequate in amount, content, and quality, mother and infant need not experience high rates of low birthweight, maternal mortality and morbidity, and other less than optimum outcomes of pregnancy. Recent research has also shown that early childbearing need not always lead to incomplete education. Two studies have reported that between 65 and 70% of women who give birth before age 20 complete 12 or more years of education or the equivalent during the years after their first birth. Since fewer than 90% of women who give birth at age 20 or later have that much education, the teen-age mothers do not look that bad. Evidence also suggests that the educational achievement of adolescent mothers has improved during the last 20 years, possibly as a consequence of the many programs which provide alternative education or support for continuation of regular education.[11]

Nor must early childbearing always lead to poverty or to large families. The same two studies show that more than half of the teen-age mothers are earning 15 thousand dollars or more by approximately 20 years after the initial

birth. By the time of the follow-up, the percentage who had received welfare benefits within the last year varied from less than 20% in one to 29% in another, but a fifth of mothers who gave birth at 20 or later also had been on welfare during the last year.

The association between early initiation of childbearing and large family size is now being questioned. Sixty two percent of the teen-age mothers in one study had only one more child and 3% had four more. In the other about 36% had one more child and 15% had four or more.

These data are from a 17 year follow-up of a Baltimore sample of black teen-age mothers[12] and a 20-year follow-up of a similar New Haven sample.[13] They do not demonstrate that teen-age pregnancy has no negative consequences, but that the consequences are not inevitable. Many young mothers lead successful lives despite the early pregnancy if they receive assistance. Both the Baltimore and New Haven samples are of women who participated in comprehensive service programs for pregnant teen-agers, but the data cannot prove that the programs were responsible for the outcomes.

THE FUTURE

One goal for the year 2000 is to prevent pregnancies among those who do not want them or who are unprepared to raise children because of their youth, lack of social supports, or economic circumstances. Many economically developed countries have been much more successful than the United States in keeping rates of teen-age pregnancy and births low, with less recourse to abortion.[14]

But since no country has been able to eliminate childbearing among adolescent women, this country must continue to experiment with imaginative programs to ensure that young mothers have healthy infants, the resources to assist their children to reach their maximum potential, and the support necessary for the mothers themselves to become productive members of society.

Achieving such goals requires action at many levels. School-based clinics and improving access to family planning clinics will have some but limited impact unless adolescent girls and boys believe that early childbearing will make it difficult or impossible to reach their personal life goals. Similarly, helping adolescents to establish realistic goals and providing assistance in meeting them will have some but limited impact unless family planning services are easily available, since major delays in initiation of sexual activity seem unlikely.

Thus, the problem of adolescent sexuality needs to be addressed in many

ways by a range of health professionals. Those who can develop contraceptives that are more suitable to the sexual practices of teen-age girls—perhaps a "morning-after pill"—and that are acceptable to teen-age boys; those who can organize accessible family planning facilities in or near schools as well as in the community; those who can plan aggressive outreach programs to bring adolescents into those facilities; and for the already pregnant, those who can offer easily available prenatal care that includes not only sympathetic and understanding medical care, but also nutritional supplementation, smoking and substance abuse cessation programs, and preparation for childbearing.

The problem of adolescent sexuality needs to be addressed by schools as well. Programs in elementary and intermediate schools should identify youngsters just beginning to show dysfunctional behaviors such as truancy or cigarette smoking. Helping parents to modify these behaviors and finding peers who will support more positive activities should reduce the incidence of adolescent pregnancy. Schools should attempt to raise the self-esteem of students, regardless of intellectual level. Certainly, bright students should be helped to reach their optimum performance level despite the economic circumstances of their families. But, perhaps more important for those at high risk of adolescent pregnancy, programs should be offered to students who may have difficulty with the standard academic curriculum. The program should help them understand the contributions they can make to society. Schools should adapt their programs to the needs of pregnant adolescents and young parents. Parenting classes, on-site prenatal care, child-care facilities, and remedial education are just a few examples of ways to help young parents overcome the handicaps of early childbearing.

Help is also needed from potential employers, businesses, nonprofit organizations, and governments. They can assist schools in showing adolescents their life options. Many poor youths have a distorted picture of the world. Inner city ghettos and isolated rural areas provide few role models of exciting and fulfilling lives, and the life style of television families are either unrealistic or unattainable. Future employers working with schools can provide a window that shows the real world, as well as opportunities for apprenticeships to prepare for that world.

Social agencies have already responded admirably to the need to prevent teen-age pregnancy and to mitigate its consequences. They have organized multiple community agencies into integrated programs for pregnant adolescents. They have developed case-management services to assist young women in negotiating complicated systems and provided badly needed social

support. They have instituted imaginative pregnancy preventive programs that involve parents and other adults. And the list of what they and other groups have and should do could be continued.

CONCLUSIONS

Premature adolescent sexuality and its consequences have multiple causes. The prevention of this activity and its negative consequences cannot be accomplished by any one agency or group of agencies. Rather a multisector approach to these problems is essential if adolescents and society generally are not to suffer needlessly. The reduction of poverty, sexism, and racism will limit the negative consequences of adolescent sexuality, including AIDS as well as teen-age childbearing. Broadly based initiatives in these areas are essential. Meanwhile, those who interact with adolescents on a daily basis must find ways to use inadequate funds and demonstration projects to meet crisis-level problems.

REFERENCES

1. Hayes, C.D., editor: *Risking the Future, Adolescent Sexuality, Pregnancy, and Childbearing*. Washington, D.C., National Academy Press, 1987.
2. National Center for Health Statistics: Advance Report of Final Natality Statistics, 1988. Monthly Vital Statistics Report. Vol. 37, No. 3, Supp. DHHS Pub. No. (PHS) 88-1120. Hyattsville, MD. Public Health Service, 1988.
3. Zelnick, M. and Kanter, J.F.: Sexual activity, contraceptive use and pregnancy among metropolitan-area teenagers: 1971-1979. *Fam. Planning Persp. 12:* 230-37, 1980.
4. Kanter, J.F. and Zelnick, M.: Sexual experience of young unmarried women in the United States. *Fam. Planning Persp. 4:*9-18, 1972.
5. Alan Guttmacher Institute: *11 Million Teenagers: What Can Be Done About the Epidemic of Adolescent Pregnancies in the United States*. New York, 1976.
6. Kisker, E.E.: The effectiveness of family planning clinics in serving adolescents. *Fam. Planning Persp. 16:*212-18, 1984.
7. Chamie, M., Eisman, S., Forrest, J.D., et al.: Factors affecting adolescents' use of family planning clinics. *Fam. Planning Persp. 14:*126-39, 1982.
8. Zabin, L.S., Hirsh, M.B., Smith, E.A., et al.: Evaluating a pregnancy prevention program for urban teenagers. *Fam. Planning Persp. 18:*119-26, 1986.
9. Pregnancy prevention programs gaining acceptance. *Ounce Prev. Fund Mag.* Winter: 4-6, 1988.
10. Zabin, L.S., Hardy, J.B., Smith, E.A., et al.: Substance abuse and its relation to sexual activity among inner city adolescents. *J. Adol. Health Care 7:*320-31, 1986.
11. McCarthy, J. and Radish, E.S.: Education and childbearing among teenagers. *Fam. Planning Persp. 14:*154-55, 1982.
12. Furstenberg, F.F., Jr., Brooks-Gunn, J., and Morgan, S.P.: *Adolescent Mothers in Later Life*. Cambridge, England, Cambridge University Press, 1987.
13. Horwitz, S.M. Personal communication.
14. Jones, E.F., Forrest, J.D., Goldman, N., et al.: Teenage pregnancy in developed countries: determinants and policy implications. *Fam. Planning Persp. 17:*53-63, 1985.